

## 0.a. Goal

Goal: 5 Achieve gender equality and empower all women and girls

## 0.b. Target

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

## 0.c. Indicator

Indicator 5.6.1: Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

## 0.e. Metadata update

March 2021

## 0.f. Related indicators

SDG Indicator 5.6.2

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

## 0.g. International organisations(s) responsible for global monitoring

United Nations Population Fund (UNFPA)

## 1.a. Organisation

United Nations Population Fund (UNFPA)

## 2.a. Definition and concepts

Definition:

Proportion of women aged 15-49 years (married or in union) who make their own decision on all three selected areas i.e. decide on their own health care; decide on use of contraception; and can say

no to sexual intercourse with their husband or partner if they do not want. Only women who provide a “yes” answer to all three components are considered as women who make their own decisions regarding sexual and reproductive health. A union involves a man and a woman regularly cohabiting in a marriage-like relationship.

Women’s autonomy in decision-making and exercise of their reproductive rights is assessed from responses to the following three questions:

1. Who usually makes decisions about health care for yourself?
  - RESPONDENT
  - HUSBAND/PARTNER
  - RESPONDENT AND HUSBAND/PARTNER JOINTLY
  - SOMEONE ELSE
  - OTHER SPECIFY
2. Who usually makes the decision on whether or not you should use contraception?
  - RESPONDENT
  - HUSBAND/PARTNER
  - RESPONDENT AND HUSBAND/PARTNER JOINTLY
  - SOMEONE ELSE
  - OTHER SPECIFY
3. Can you say no to your husband/partner if you do not want to have sexual intercourse?
  - YES
  - NO
  - DEPENDS/NOT SURE

A woman is considered to have autonomy in reproductive health decision making and to be empowered to exercise their reproductive rights if they (1) decide on health care for themselves, either alone or jointly with their husbands or partners, (2) decide on use or non-use of contraception, either alone or jointly with their husbands or partners; and (3) can say no to sex with their husband/partner if they do not want to.

## **2.b. Unit of measure**

---

Proportion.

## **2.c. Classifications**

---

Adopted by 179 governments, the 1994 International Conference on Population and Development Programme of Action marked a fundamental shift in global thinking on population and development

issues. It moved away from a focus on reaching specific demographic targets to a focus on the needs, aspirations and rights of individual women and men. The Programme of Action asserted that everyone counts, that the true focus of development policy must be the improvement of individual lives and the measure of progress should be the extent to which we address inequalities. For more information on ICPD Programme of Action, please visit [https://www.unfpa.org/sites/default/files/pub-pdf/programme\\_of\\_action\\_Web%20ENGLISH.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf).

### **3.a. Data sources**

---

Data are mainly derived from nationally representative Demographic and Health Surveys (DHS). Data sources increasingly include Multiple Indicator Cluster Surveys (MICS) and Generations and Gender Surveys (GGS), and other country-specific household surveys.

### **3.b. Data collection method**

---

Data is collected in line with the methodology used for the relevant national survey.

Data for SDG indicator 5.6.1 may be collected through existing county-specific surveys. For existing national household surveys, it must be ascertained that the sampling design does not systematically exclude subgroups of the population that are important to SDG 5.6.1, specifically, women of reproductive age (15-49) that are currently married or in union. Surveys that cover only certain population subgroups, such as women who speak the dominant language or women from the main ethnic group, may exclude the experiences of a large number of women. Data on the ethnicity and religion of the survey participants should be collected whenever available. The survey should have a large sample size (usually between 5,000 and 30,000 households), be nationally-representative, and representative, at least, at one administrative level below the national level.

Surveys on unrelated topics may not be good candidates for the incorporation of the SDG 5.6.1 questions. The sensitivity of the topics addressed in health surveys, in particular, those examining women's health, making them a feasible instrument for incorporating questions on women's experience of decision making in sex relations, use of contraceptive, and health care for themselves.

In order to generate data for SDG 5.6.1, all three questions must be included in the survey. The three questions in the Definition section provides generic questions that can be used in country-specific surveys. For the first and the second questions, these should include distinct categories for women making decisions herself, and women making decisions jointly with her husband/partner.

### **3.c. Data collection calendar**

---

As per DHS, MICS, GGS and country-specific survey cycles

### **3.d. Data release calendar**

---

Annual

### **3.e. Data providers**

---

Agencies responsible for household surveys at national level.

### 3.f. Data compilers

---

UNFPA

### 3.g. Institutional mandate

---

The mandate of UNFPA, as established by the United Nations Economic and Social Council (ECOSOC) in 1973 and reaffirmed in 1993, is (1) to build the knowledge and the capacity to respond to needs in population and family planning; (2) to promote awareness in both developed and developing countries of population problems and possible strategies to deal with these problems; (3) to assist their population problems in the forms and means best suited to the individual countries' needs; (4) to assume a leading role in the United Nations system in promoting population programmes, and to coordinate projects supported by the Fund.

At the International Conference on Population and Development (ICPD), held in Cairo in 1994, these broad ideas were elaborated to emphasize the gender and human rights dimensions of population. UNFPA was given the lead in helping countries carry out the Programme of Action adopted by 179 governments at the Cairo Conference. In 2010, the United Nations General Assembly extended the ICPD beyond 2014, which was original end date for the 20-year Programme of Action.

### 4.a. Rationale

---

Women's and girls' autonomy in decision making about sexual and reproductive health services, contraceptive use and consensual sexual relations is key to their empowerment and the full exercise of their reproductive rights.

Women who make their own decision regarding seeking healthcare for themselves are considered empowered to exercise their reproductive rights.

Regarding decision-making on use of contraception, a clearer understanding of women empowerment is obtained by looking at the indicator from the perspective of decisions being made "mainly by the partner", as opposed to decision being made "by the woman alone" or "by the woman jointly with the partner". Depending in the type of contraceptive method being used, a decision by the woman "alone" or "jointly with the partner" does not always entail that the woman is empowered or has bargaining skills. Conversely, it is safe to assume that a woman that does not participate, at all, in making contraceptive choices is disempowered as far as sexual and reproductive decisions are concerned.

A woman's ability to say no to her husband/partner if she does not want to have sexual intercourse is well aligned with the concept of sexual autonomy and women's empowerment.

### 4.b. Comment and limitations

---

Until recently, the indicator captured results for married and in-union women and adolescent girls of reproductive age (15–49 years old) who are using any type of contraception. In the phase of the national Demographic and Health Survey (DHS–7) and later rounds, as well as in other data collection instruments including the MICS and GGS, the questionnaire are extended to respondents whether they

are using contraception or not. The measure does not cover women and girls that are not married or in union, as they do not usually make “joint decisions” on their own health care with their partners.

As of early 2021, a total of 64 countries, the majority in sub-Saharan Africa, have at least one survey with data on all three questions necessary for calculating Indicator 5.6.1. Broader data sources are needed and efforts to increase data coverage are underway.

In many national contexts, household surveys, which are the main data source for this indicator, exclude the homeless and are likely to under-enumerate linguistic or religious minority groups.

## 4.c. Method of computation

---

Numerator: Number of married or in union women and girls aged 15-49 years old:

- for whom decision on health care for themselves is not usually made by the husband/partner or someone else; and
- for whom the decision on contraception is not mainly made by the husband/partner; and
- who can say no to sex.

Only women who satisfy all three empowerment criteria are included in the numerator.

Denominator: Total number women and girls aged 15-49 years old, who are married or in union.

Proportion = (Numerator/Denominator) \* 100

## 4.d. Validation

---

Annual country consultation on new and existing data that were calculated from survey microdata sets was conducted in the first three years of the SDG reporting. Countries are encouraged to publish indicator data in the survey reports.

## 4.e. Adjustments

---

Not applicable.

## 4.f. Treatment of missing values (i) at country level and (ii) at regional level

---

- At country level

No attempt from UNFPA to provide and publish estimates for individual countries or areas when country or area data are not available.

- At regional and global levels

Regional aggregates are based on countries where data are available within the region. They should not be treated as country-level estimates for countries with missing values within the region.

## 4.g. Regional aggregations

---

Global and regional aggregates are computed as weighted averages of country level data. The weighting is based on the estimated population of married women aged 15-49, who are using any type of contraception in the reporting year. The estimates of number of women married/ in union and contraceptive prevalence rate are obtained from UN Population Division.

## 4.h. Methods and guidance available to countries for the compilation of the data at the national level

---

For more information, please refer to <https://www.unfpa.org/sdg-5-6>. Further guidelines on collecting data for SDG 5.6.1 in national household surveys is available upon request.

## 5. Data availability and disaggregation

---

Data availability:

Currently, a total of 64 countries have at least one survey with data on all the 3 questions above which are necessary for calculating Indicator 5.6.1. The 64 countries with data are distributed as follows:

- Central Asia and Southern Asia (7)
- Eastern Asia and South-eastern Asia (5)
- Northern America and Europe (5)
- Western Asia and Northern Africa (3)
- Latin America and the Caribbean (7)
- Sub-Saharan Africa (36)

Several other countries have only one or two of the three questions needed to calculate Indicator 5.6.1. UNFPA engages with major international and regional survey programmes, as well as national and international organizations and agencies to incorporate the questions in relevant household surveys with a view to covering all countries on a global scale.

Time series:

Currently data comes from household surveys which have three to five- year cycles.

Disaggregation:

Based on available household survey data, disaggregation is possible by age, geographic location, place of residence, education, and wealth quintile.

## 6. Comparability/deviation from international standards

---

Sources of discrepancies:

Not applicable.

## 7. References and Documentation

---

URL:

<https://www.unfpa.org/sdg-5-6>

References:

Not available.